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| **APPLICATION CHECKLIST** |
|  | Application – Completed, as directed in black ink |  | Dental Referral Form |
|  | Contract – Read and signed by parent(s) and applicant |  | Report Card  |
|  | Applicant Questionnaire – Handwritten by the applicant |  |  |
|  | Household Information – Complete and accurate  |  |  |
|  | 2 Letters Of Recommendation – Letters from at least two community leaders or teachers, with contact information attached |
|  | 2 Photos – Close up photos of applicant’s teeth while smiling. (1) photo, teeth showing from the front and (1) photo of the teeth from the side. |

**IT IS YOUR RESPONSIBILITY TO ENSURE ALL DOCUMENTS ARE INCLUDED. WE WILL NOT NOTIFY YOU IF YOUR PACKET IS INCOMPLETE!**

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| **ORTHODONTIC SCHOLARSHIP** |
| Smile for a Lifetime (S4L) is an international program that provides orthodontic scholarships (free braces) to children ages 11-17 who normally would not be  |
| able to afford treatment. Dr. Mattiacio has formed a local chapter to serve children in Farmington, NY. There is no cost to those chosen |
| to receive an S4L orthodontic scholarship.  |
|  |
| Scholars are chosen by a local board of directors and the process is competitive. **Scholarships are limited** and based on financial need, orthodontic need, and |
| a complete and accurate application.  |
| **QUALIFICATIONS** |
| * Applicant must reside in Yates, Seneca or Livingston counties of New York.
 |
| * Family income of no more than (185%) of the federal poverty level. (Income eligibility form attached)\*
 |
|  **If** **Chosen**, proof of income will be **required** to verify eligibility prior to treatment. W-2, Income tax return, SSI award letter, TANF grant letter etc. |
| * Applicant must be between the ages of 11 – 18.
 |
| * Have “good” dental hygiene practices and had a dental hygiene check-up in the past 6 months.
 |
| * Must have a functional and/or aesthetic need for braces.
 |
| * Must currently be enrolled in school.
 |
| * Must demonstrate a positive attitude.
 |
| * Must follow and abide by treatment plan set forth by the orthodontist and contract attached.
 |
| * Should demonstrate a willingness to get involved in the community through extracurricular activities and/or volunteer service.
 |
| * Must have positive letters of recommendation from at least two community leaders and/or teachers.
 |
| **\* Chapter may consider exceptions under the “special circumstances” clause. Please speak with an S4L representative for more information** |
| **NOTE: If awarded, Proof of income is required prior to treatment. i.e. W-2, Income Tax Return for previous year, SSI Award Letter, Child Support, TANF grant letter, etc.** |
| **APPROVAL PROCESS** |
| * The screening committee for the Mattiacio Orthodontics of Smile for a Lifetime will select applicants on an ongoing basis.
 |
|   |
| * Selection is based on the information provided within this packet (i.e. commentary, personal essay, character, and accompanying letters of recommendation),
 |
|  orthodontic and financial need. |
|  |
| * Please ensure that the packet is filled out completely and accurately. Incomplete packets will not be submitted to review board for selection process.
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| * If you would like to reapply, please speak with an S4L representative for further information.
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| **ORTHODONTIC SCHOLARSHIP APPLICATION FORM** |
| Today’s Date:  | Primary Dentist: |

 APPLICANT INFORMATION

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| --- | --- | --- | --- | --- |
| Applicant’s Last Name: |  | First:  |  |  Middle: |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Applicant’s Date Of Birth (MM/DD/YYYY): |   |  Applicant’s Age:  |   | Applicant’s Gender: | MALE | FEMALE |
| Are you currently enrolled in school: | YES | NO |  What grade are you in :  |   | What is your GPA: |  |
| Name of School: | Address (City, State, Zip Code): | Phone Number: | ( ) |
|  |  | Fax: | ( ) |
| Are you wearing braces? | If you are over the age of 16, what are your plans over the next 3 years (Moving, College, etc.): |
|  |
| Home Address:  | City: | State: | Zip: | Home phone no.:  | Cell phone no.:  |
|  |  |  |  | ( ) | ( ) |
| How did you hear about Smile for a Lifetime (please circle or write in your answer)? |
| Internet Search | Family | Friend | Dentist/Orthodontist | Boys & Girls Club | State Office | Other:**(Please Specify)** |
| Television | Magazine | Radio | Newspaper | CASA | Internet Ad |  |
| Are you a member of any of the following organizations? Circle all that apply: | BBBS | BGCA | CASA | NCOHF |
|  |
| **There are many reasons why people get braces; please select the following that apply or feel free to add your own:** |
|  | Discomfort while eating/drinking |  | Jaw and/or mouth pain |  | I look down when talking |
|  | Speech Impediment |  | I get teased about my teeth |  | I cover my mouth when I laugh |
|  | It’s hard to clean my teeth well |  | I’m embarrassed to smile |  | I have a hard time sleeping/Sleep apnea |

**GUARDIAN INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Guardian’s Name: | Guardian’s Occupation: | Guardian’s Employer: | Employer phone no.: |
|  |  |  | ( ) |
| Guardian’s Name: | Guardian’s Occupation: | Guardian’s Employer: | Employer phone no.: |
|  |  |  |  ( ) |
|  Have any other children in the household been treated through Smile for A Lifetime (If so, whom)? |
|  |
| Please explain in detail why you would like your son or daughter to be awarded an orthodontic scholarship through Smile for a Lifetime. |
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|  What is the best way to reach you?: |   |  Phone: ( ) |   |  Email: |
| **APPLICANT QUESTIONNAIRE** |
| **HANDWRITTEN BY THE APPLICANT ONLY. Each question must be answered in essay format 5 to 7 sentences in length.\*** |
|  Tell us about yourself. What do you like to do? Favorite hobbies, extracurricular activities, and the types of goals and aspirations in life. etc. |
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| Tell us about your family. How many siblings do you have, who are they, do they live with you, what do you like to do together? etc. |
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| Please tell us, in detail, why you would like braces and/or orthodontic treatment and how will orthodontia change your life? Etc. |
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| If you had a chance to do a favor for another person/organization, without any expectation of being paid back, what would you do and why?  |
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| **\*If the minimum requirements are not met, your application will be considered incomplete and not included in selection process.** |
| **CONTRACT** |
| **If** selected from the pool of applicants by the screening committee of Smile for a Lifetime Mattiacio Orthodontics to receive orthodontic  |
| treatment, there are a few guidelines required for treatment. Throughout the selection process there is some professional guidance provided, if requested, but the |
| decision is largely subjective and based on the completeness of the application, commentary, personal essay, character and the accompanying letters of reccomenda- |
| tion submitted with your packet. Orthodontic treatment for Mattiacio Orthodontics Chapter of Smile for a Lifetime will be provided by Dr. Mattiacio and the  |
| team in his office .  |
| **By submitting and signing this application you understand and agree to the following:** |
| 1. I agree that appointments will be at the discretion Dr. Mattiacio and his team.
 |
| 1. I understand that this can mean scheduling appointments during non-peak hours.
 |
| 1. I acknowledge that appointments must be kept in order to achieve an expeditious and desirable result.
 |
| 1. I also understand that keeping appointments is essential to treatment success and is a requirement of accepting care from Dr. Mattiacio.
 |
| 1. If you must reschedule appointments, give the practice at least 24 hours’ notice. If more than two appointments are missed or appointments are
 |
| constantly rescheduled it will be considered out of compliance which is grounds for removal of braces and revocation of scholarship. |
|  6) If you *must* relocate prior to the conclusion of treatment, Smile for a Lifetime will do its best to find another service provider. However, it is not  |
|  guaranteed that Smile for a Lifetime will have another provider available in the area and/or can continue to provide treatment as a result. |
| 1. One retainer will be provided as a part of the scholarship award, any replacements will not be covered by or Smile for a Lifetime or Mattiacio Orthodontics
 |
| Chapter of Smile for a Lifetime. |
| 1. **Direct responsibilities of the patient:**
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| 1. Maintain excellent oral hygiene (tooth brushing, flossing). If unwilling to meet expectations due to medical and dental health risks, treatment will be discontinued.
 |
| 1. Follow the rules for eating habits. This will greatly reduce breakage of appliances (i.e. braces) and it is necessary for satisfactory completion of treatment.
 |
| 1. Cooperate. More than two (2) loose brackets may be deemed sufficient evidence that cooperation is not sufficient to meet minimal requirements for treatment.
 |
|  d) Other cooperation issues are with failure to cooperate with maintenance of auxiliaries including elastics, wearing head gear, and springs. |
| 1. Attitude. You will be expected to maintain an exceptionally appreciative and respectful attitude once accepted into orthodontic treatment or any other aspect of treatment
 |
|  supported by Dr. Mattiacio or Smile for a Lifetime. Rude behavior or an inappreciative attitude is unacceptable. |
| 1. **ATTENTION:** Failure to fulfill your responsibilities may result in removal of orthodontic equipment and discontinuation of treatment
 |  **Applicant Initials: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 1. **ATTENTION:** Honesty is expected. Any misrepresentation, falsification or exclusion of income will be grounds for dismissal from the program. Future applications
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|  will not be considered. There are many deserving children who are in need of orthodontics, we are here to serve those in greatest need. |  **Guardian’s Initials**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **Media Disclaimer**: If your child is the chosen applicant, you consent to Smile for a Lifetime’s (S4L) use, without charge, of all photos, video and audio recordings of your child. S4L may,
 |
| 1. Copyright, broadcast, display, publish, re-publish and reproduce your child’s image, voice and any statements made by him/her, in whole or in part, in any and all media forms; and
 |
| 1. Assign your child a fictitious name or use his/her first name, likeness, video, photograph, voice, statements and biographic or other information concerning his/her participation with
 |
|  S4L for fundraising or other promotional and advertising purposes. You and your child also agree to participate in surveys and case management during and after receiving treatment. |

 |
| **Legal Guardian Consent:** I certify that I am the legal guardian of the child listed on this application. I have all rights and authority to make medical decisions for the child, that all information  |
|  in this application is true and correct. |
| **This scholarship is intended specifically for underserved and deserving children in the community. There are many children who need and deserve an**  |
| **award winning smile and while we do our best to serve those greatest in need, it is a competitive process and not everyone will receive a scholarship.**  |
| **Please take your time on your application; your time and effort will be taken into consideration when selecting applicants for scholarships.** |
|  |  |  |  |  |
|  |  |  |  |  |
| Applicant’s Name (Printed First, MI, Last) |  | Applicant’s Signature |  | Date |
|  |  |  |  |  |
| Guardian’s Name (Printed First, MI, Last) |  | Guardian’s Signature |  | Date |
|  |  |  |  |  |
| Guardian’s Name (Printed First, MI, Last) |  | Guardian’s Signature |  | Date |

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